State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

IF YOU ARE ELIGIBLE FOR FAMILY PACT, MEDI-CAL MAY REIMBURSE YOU FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH EXPENSES YOU PAID

You may be able to be reimbursed for some expenses you paid. The California Department of Health Care Services (DHCS) will assist you in getting your money back if all criteria below are met:

1. You received a Family PACT-covered family planning and reproductive health service during the 3-month period prior to the month you were initially certified for participation in the Family PACT program.
2. You paid for your family planning service, or another person paid for your family planning service on your behalf. You must provide proof that the family planning service was paid for by you or another person and provide an itemized list of services covered by the payment.
3. This form (DHCS 4001) must be certified by a Family PACT provider for you to be eligible for retroactive reimbursement.
4. You do not seek reimbursement for co-payments or excess Share of Cost charges. Reimbursement for valid claims will not exceed the Family PACT rate for the covered service at the time the service was rendered.
5. The medical provider was in California.
6. You are required to provide documentation of medical necessity if authorization is required for the service rendered.
7. You were eligible to receive that specific family planning service.
8. The family planning service was a benefit under the Family PACT program.
9. You give the Beneficiary Service Center permission to contact you and/or your Family PACT provider directly.
10. You authorize your medical providers to release necessary records to verify this claim.

Important dates and time frames:

- You must submit your claim within one year of the date of the service. A Claim not submitted within one year of the date of a service will be denied. Only that portion of the claim that is within the allowable timeframe, if any, will be considered for reimbursement.

To file a claim for reimbursement or for more information call:

Beneficiary Service Center - Family PACT, (916) 403-2007 TDD: (916) 635-6491

****REMEMBER TO KEEP ALL RECEIPTS FOR THE FAMILY PLANNING AND REPRODUCTIVE HEALTH CARE YOU RECEIVED****

The Beneficiary Service Center will review your claim and send you a letter describing the status of your claim. If you disagree with any action taken, you may ask for a state hearing. The letter will tell you how to ask for a state hearing.

Your Rights:

You have the right to request a state hearing to review a Beneficiary Service Center decision or action regarding your request for a Beneficiary Reimbursement. You must request a state hearing within 90 days of the date on the Notice of Action that informs you of the decision or action that was mailed to you by the Beneficiary Service Center. Please follow the instructions provided in the Notice of Action to request a state hearing or call the California Department of Social Services' State Hearings Division at 800-952-5253. For TDD service, call 1-800-952-8349. Written requests must be mailed to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-99
Sacramento, CA 94244-2430

Privacy Statement (Civil Code Section 1798 et seq.)

Civil Code, Section 1798.17, and the Federal Privacy Act, 5USC 552a, subdivision (e)(3), require this notice be provided when collecting personal or confidential information from individuals.

NPI number:		HAP Identification number:

HEALTH ACCESS PROGRAMS
FAMILY PACT PROGRAM
RETROACTIVE ELIGIBILITY CERTIFICATION (REC)

This form is the property of the State of California, Department of Health Care Services, Office of Family Planning, and cannot be changed or altered.
Please ***print*** answers to all questions. The questions about your family size, income, and health care insurance are to determine if you are eligible for retroactive eligibility. Providers must keep a copy of this form for three years.

First name	**Middle name**	**Last name**	**Suffix (Jr., Sr.)**

Circumstances:	***Month/Year:***	***Month/Year:***	***Month/Year:***
Were you a California resident?	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
Did you receive Medi-Cal benefits or services?	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
Did you have a Medi-Cal Benefits Identification Card (BIC)? BIC number: _____ Issue date: _____	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
Did you have health care insurance for family planning services? (Private insurance, Health Maintenance Organization (HMO), Managed Care Plan, Student Health Insurance, etc.)	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***

Eligibility Determination: Please list all family members (self, spouse, and children) that were living in your household and supported by the family income. List the source of any earned or unearned income and the amount of income, including income from employment, self-employment, tips, commissions, pensions, social security, child and/or spousal support, ongoing insurance payments, disability, Veterans Affairs, unemployment benefits, etc.

Month/Year	**Name(s)**	**Relationship to You**	**Age(s)**	**Source(s) of Income**	**Gross Monthly Income (Before Taxes)**	**Family Size/ Total Family Income**

I declare under penalty of perjury under the laws of the state of California that the foregoing information on this form is true and correct. I understand that the giving of false information may make me ineligible for this program. I give the Beneficiary Services Center permission to contact me or my provider for the purpose of processing my claim.

THIS IS NOT A CLAIM FORM. YOU MUST FIRST CALL THE BENEFICIARY SERVICE CENTER at (916) 403-2007 to request a claim packet. To be considered for reimbursement you must request, complete and submit a claim form. DO NOT submit this REC form without attaching a COMPLETED CLAIM FORM.

Signature (or mark) of applicant	Date	Signature of witness to mark or interpreter	Date
Street Address		City	Zip code
Phone number			

FOR PROVIDER USE ONLY

	Month/Year:	***Month/Year:***	***Month/Year:***
Retroactive Eligible for Family PACT Program	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
Medi-Cal client eligible for Family PACT verified	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***

Based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this Retroactive Eligibility Certification is eligible to receive retroactive eligibility under the Family PACT Program. If ineligible, the client has received a copy of this form which includes the Fair Hearing Rights on the reverse side. I also certify that the client has received the Notice of Privacy Practices.

Print name	Signature	Date
Street Address	City	Zip code
NPI:	Phone Number	